

Continuing COVID-19 Policy Flexibilities Affecting Children and Youth with Special Health Care Needs: Recommendations for the California Department of Health Care Services and other State and Local Actions

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Policy and regulatory changes enacted during the COVID-19 public health emergency (PHE) have significantly impacted children and youth with special health care needs (CYSHCN), their families, and their health care providers.

In an effort to address or ameliorate the impact of the pandemic on access to and utilization of health care services, the federal government and state governments created temporary flexibilities through a variety of legislative, regulatory, and administrative mechanisms. With support from the Lucile Packard Foundation for Children's Health, Health Management Associates conducted a comprehensive review of these policy changes and identified those with particular implications for CYSHCN. We discussed these flexibilities and their impact on CYSHCN with frontline clinicians, legal and family advocates for CYSHCN, researchers, program leaders, and other public and private stakeholders.

The study's findings, which can be found at lpfch.org/COVID-19-HMA-Report include the following:

- Policies that expanded reimbursement for telehealth¹ have significantly affected and been largely advantageous to CYSHCN and their families. These included flexibility in services provided via telehealth, patient and practitioner location, technologies used, and types of providers.
- Expansions in telehealth also highlighted disparities, however, as many low-income and rural families face language barriers or lack broadband access, technologies required for telehealth, safe locations from which to conduct visits in private, or training on how to request or use telehealth. Further, states, health systems, and providers did not consistently adopt the flexibilities and make telehealth opportunities universally available, suggesting additional access challenges and inequities that warrant further study.
- To soften the pandemic's negative impact on access to care, the federal government and state governments also relaxed provider enrollment, eligibility, and out-of-state licensure requirements for Medicare and Medicaid; broadened the scope of practice for certain health care workers; reduced administrative requirements for accessing specialty care and services; and expanded the ability of states to pay family caregivers for providing personal care to CYSHCN.
- The sudden and long-term school closures, isolation, cessation of many in-person clinical visits and home care visits (both home health and personal care/direct services), lack of child care and respite care, rampant unemployment, and social determinants of health (SDOH) that have been created or exacerbated by the pandemic have put tremendous strains on CYSHCN and their families. While use of telehealth for behavioral health services has increased significantly, there has been a dearth of policies or flexibilities focused on identifying and addressing the new stressors on CYSHCN and their caregivers.

Given what has been learned so far, Health Management Associates developed recommendations about temporary policy changes that should continue or cease after the PHE, as well as new actions for consideration to best serve CYSHCN and their families and better prepare for future emergencies. ***This policy brief presents recommendations for the California Department of Health Care Services (DHCS), which administers the state's Medi-Cal (Medicaid) program, and for additional state and local actions to improve access and delivery of services to CYSHCN in California.***

Recommendations for Retaining and Advancing Telehealth Policies

California has a long history of progressive telehealth (formerly telemedicine) legislation dating to the Telemedicine Development Act of 1996 and several subsequent Acts. The California Telehealth Advancement Act of 2011 (AB 415) enabled the Medi-Cal program to expand service types and reimbursement for services delivered through telehealth. In 2019, additional expansions were legislated—some of which were immediately effective (e.g., remote prescribing with an “appropriate prior examination...that does not require a synchronous interaction”^{2,3}). Other provisions were to take effect in January 2021 (e.g., payment parity for telehealth services for commercial plans⁴ and removal of limitations on services that could be delivered and reimbursed via asynchronous “store-and-forward”⁵ technologies⁶).

During the COVID-19 pandemic in 2020, DHCS implemented additional telehealth flexibilities through the PHE-related federal waivers and flexibilities—particularly Medicaid Section 1135 blanket waivers and Disaster Relief State Plan Amendments. A list of the temporary policy changes in California during the PHE can be found in guidance issued by DHCS.⁷ In February 2021, DHCS indicated which of the temporary policy changes from the PHE they would retain and additional policy changes (unrelated to the PHE) they are implementing effective July 1, 2021 (or in accordance with federal approvals).⁸

After reviewing and analyzing the planned post-COVID-19 changes, the authors support the state's interest in maintaining and advancing the following policies to promote access to services for CYSHCN:

- Expanding the use of clinically appropriate telephonic/audio-only services, other virtual communication, and remote patient monitoring for established patients (under the state's planned policy changes, these modalities would be subject to a separate fee schedule and not be billable by federally qualified health centers [FQHCs]/rural health clinics [RHCs]).
- Expanding synchronous and asynchronous telehealth services to beneficiaries of 1915(c) waivers (four of which are open to children: Home- and Community-based Waiver Alternatives; Home- and Community-based Waiver for Californians with Developmental Disabilities; Self-Determination Waivers for Californians with Developmental Disabilities; HIV/AIDS Waiver); the Targeted Case Management Program; and the Local Education Agency Medi-Cal Billing Option Program.
- Payment parity for synchronous telehealth modalities (including for FQHCs/RHCs). Payment parity will continue to be required in both fee-for-service and managed care delivery systems unless a managed care plan and a network provider mutually agree to another reimbursement methodology.
- Allowing specified FQHC and RHC providers to establish new patients through synchronous telehealth (i.e., not requiring in-person visit) if they are located within the center's federal designated service area.
- Making permanent the removal of the site limitations on FQHCs and RHCs (e.g., continue reimbursement for telehealth services originating in the beneficiary's home).

Moreover, the authors recommend the following Medi-Cal telehealth flexibilities be maintained:

- *Payment parity for synchronous telephonic/audio-only services, e-visits, and e-consults, especially for behavioral health visits, and including reimbursement at least at Prospective Payment System rates for FQHCs/RHCs.* Alternatively, for FQHCs/RHCs, the state could consider payment parity for audio-only services for a period of time while discussions about alternative payment methodologies proceed.
- Consideration of synchronous telephonic/audio-only services and other virtual communication *for new patients under prescribed circumstances* such as for children with medical complexity who cannot access in-person services within a reasonable time period (i.e., other than hospital or emergency department services); administrative transitions or transfers of care that do not involve a change in medical status; and natural disasters or other circumstances that pose unusual access challenges.
- Clarifying and supporting coverage for *care coordination* services via telehealth as a reimbursable service for both licensed and certified providers (i.e., to include medical assistants, certified nurses' aides, certified community health workers, social workers).

California's DHCS has committed to continuing dialogue with providers and telehealth advocates so the state is positioned to remain a leader in telehealth. We recommend that those dialogues include discussions regarding pilots to expand the use of telehealth modalities including *texting*, especially for young people who may not have privacy for telephone calls.

Recommendations for Other Access-Related Policies

Medi-Cal Access-Related Actions

While there already has been extensive discussion about which telehealth policies to retain after the COVID-19 PHE is over, there has been less discussion about other policies to retain post pandemic. It is possible that topic-specific workgroups involved in the planning for implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative will address and make recommendations about retaining other policies that were implemented during the PHE. The CalAIM initiative was developed to design delivery system, program and payment reforms to fully integrate waiver and pilot programs (e.g., Whole Person Care, Section 2703 Health Homes, the Coordinated Care Initiative) into Medi-Cal managed care. The effort is being informed by several stakeholder workgroups, all of which are relevant to CYSHCN, including groups focused on the Foster Care Model of Care, Managed Long-term Services and Supports and Duals Integration, Enhanced Care Management (ECM) and In Lieu of Services (ILoS), Behavioral Health, Population Health Management Strategy, and Full Integration Pilots.

Regardless of whether the CalAIM workgroups address the COVID-19-related flexibilities, DHCS should consider the following:

- The California DHCS should coordinate with the federal government, the public and private health care sector, and philanthropy to thoroughly *evaluate the impact of the temporary policy flexibilities* on access, utilization, physical and mental health, child/family experience, and developmental outcomes for CYSHCN and other at-risk populations. In particular:
 - DHCS should assess the impact of suspending prior authorizations on the Medi-Cal program, providers, and beneficiaries, then *modify those authorization requirements* accordingly beyond the PHE (while continuing to monitor quality and cost-effectiveness). This is entirely within the control of DHCS for fee-for-service Medi-Cal, including the California Children's Services (CCS) population, and could be done in conjunction with Medi-Cal managed care plans for the managed care population.
 - Extension of Medi-Cal *provider enrollment and eligibility flexibilities* should be considered for provider types where there is an established beneficiary need and ongoing workforce shortages, such as for speech therapists, psychiatric/mental health nurse practitioners and other mental health professionals (and others as would be determined from a more thorough analysis of beneficiary utilization and wait times for CYSHCN), but only if those flexibilities do not sacrifice quality. Any provider qualification standards that are found to have compromised quality of care should cease.
- To further support critical care coordination for CYSHCN beyond the PHE, DHCS should *clarify that care coordination is a covered benefit under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), secure and increase Medi-Cal reimbursement for care coordination services for CYSHCN, and consider covering care coordination by certain paraprofessionals and other service providers* to address non-medical needs (a targeted recommendation about care coordination via telehealth is included in the section above). At present, care coordination services are reimbursable for adults (especially through the Whole Person Care and Health Home pilots), as are both *case management* and *Targeted Case Management* as part of the EPSDT benefit. There continues to be confusion and health plan-level disputes about reimbursement for care coordination for children.⁹
- Given that the pandemic highlighted disparities and unmet SDOH needs, and the increased focus on population health management in CalAIM discussions (there is both a separate CalAIM population health management workgroup and a plan to grandfather Whole Person Care and Health Home participants in the first wave of the ECM/ILOS model implementation), DHCS should *incentivize and reimburse for SDOH screening (using approved instruments), referrals, and interventions*. Examples may include incorporating an SDOH screening measure in the Managed Care Accountability Set, pay-for-performance incentives, inclusion as a directly reimbursable screening using Proposition 56 funds, or as a requirement for the CalAIM's ECM or ILOS for children and youth with complex needs.
- The California DHCS should retain the expansion of Medi-Cal *payment to family caregivers*, including legally responsible caregivers, who provide personal care and health-related services to CYSHCN. This would likely require an updated state plan or revisions to the 1915(c) waivers whereby the Centers for Medicare & Medicaid Services waives the exclusion of payments to legally responsible relatives. DHCS should develop communication channels to inform families of this benefit, design a user-friendly application process, and provide appropriate training and "guardrails" to assure quality and program integrity.

- The need for identifying providers that are clearly accountable for the well-being of CYSHCN is heightened during emergencies such as the pandemic. For some CYSHCN receiving services in special care centers, those providers and staff made efforts to proactively see to their needs. But for many, specialists confine their scope with these children to conditions directly related to their chronic condition and feel uncomfortable or unable to care for their preventive and primary care needs and other SDOH. Both the Whole Child Model (the multiyear pilot that “carves-in” to the Medi-Cal managed care plans the special care services that were previously delivered and reimbursed through the California Children’s Services program as fee-for-service benefits) and CalAIM create opportunities for California to *test and support value-based, comprehensive service and reimbursement models for pediatric care and for CYSHCN*. Such models might include not only program “carve-ins” but also accountable care organizations, health homes, outcomes/value-based payment contracting, shared-savings, and patient- and family-centered medical homes to the degree they are positioned for value-based payment.

Additional Access-Related State Actions

- *California agencies should convene a multi-agency, public-private post-COVID assessment to determine improvements that should be made on behalf of CYSHCN as part of future disaster preparedness.* While the California Department of Public Health and the Department of Education collaborated on permitting in-person services and supports to targeted CYSHCN, that guidance from the Department of Education was not released until late August 2020 (months into the pandemic), and the emphasis was primarily limited to children with learning disabilities absent other medical complexities. Yet interviews with stakeholders for this study underscored the need for schools to have plans in place to continue or re-establish therapeutic and other health-related, school-based services in the event of another emergency. Interagency collaboration at the state and local level is critical to ensuring that the needs of all CYSHCN are incorporated and appropriately prioritized, particularly during emergency and disaster planning.
- The California Future Health Workforce Commission should mobilize to *address shortages in the home care workforce*, which were exacerbated during the pandemic. The Commission recommended in its 2019 final report a universal home care worker “family of jobs” with associated career ladders and training.¹⁰ In February 2021, a state auditor’s report of the In-Home Supportive Services (IHSS) program revealed a growing gap between the supply and demand for IHSS workers, owing largely to relatively low wages with little opportunity for wage increases over time.¹¹ Despite these two reports that underscored this huge need, so far in the current legislative session, there is no focus on home care workers in the recent collection of legislation on workforce issues. In addition to refocusing on the Commission report’s recommendations, California might explore building a pipeline utilizing education programs for both professionals and paraprofessionals, including family caregivers; increasing Medi-Cal reimbursement rates for home care workers (home health nurses, for example, consistently earn less than hospital-based workers); developing Certified Nursing Assistant training programs open to family members including legally responsible caregivers (e.g., spouse and parent);¹² and continuing home- and community-based waiver program retainer payments to home-based caregivers while a beneficiary is temporarily institutionalized (even if unrelated to COVID-19).

Recommendations to Support Mental Health Care for CYSHCN and Caregivers

California struggled with the increase in behavioral health symptoms and diagnoses during the PHE. Unique burdens felt by family caregivers of CYSHCN led to burnout, anxiety, and mood disorders among other conditions. While the state provided general resources, hotlines, and referral links, the local departments of mental health provided more detailed, patient-facing resources and behavioral health services. The following are recommendations to enhance support of mental health wellness among CYSHCN and their families/caregivers during disasters:

- Make permanent the flexibility to transfer available prudent reserve funding from the Mental Health Services Act to Prevention and Early Intervention and Community Services and Supports (CSS) in order to meet local needs. (AB 81 made this flexibility available during the PHE.)
- Mobilize state and local leaders to identify creative mechanisms for incentivizing and encouraging more *routinized behavioral health screenings and services* for CYSHCN and their families enrolled in CCS or Medi-Cal. During disasters, behavioral health screenings and basic services may be best positioned as a primary care or special care center responsibility for this population (rather than a behavioral health responsibility) given the variable nature of behavioral health carve-outs in the Medi-Cal programs.
- While reimbursement for *telehealth modalities for behavioral health services* will be extended beyond the PHE, approval and reimbursement for *screening patients new to behavioral health services including telephonic/audio-only visits*, should be authorized as an exception during any disaster.

Recommendations for CCS: State and Local Level

In California, the CCS program is jointly administered by the state DHCS and the county health departments. The program provides diagnostic and treatment services, medical case management, and therapy services for children under 21 years of age with eligible conditions. The CCS program also ensures the quality of specialty providers and special care centers and authorizes specialty services in most counties where those services are still carved out from Medi-Cal managed care. (In the 21 counties participating in the CCS Whole Child Model program, service authorization is managed according to policies and procedures of the Medi-Cal managed care plans.)

During the PHE, the state CCS program operated under the guidance of DHCS COVID-19-related regulatory flexibilities except in three areas. First, CCS continued the requirement for service authorization requests for most CCS services. Second, the CCS program issued two-staged guidance about access to services through the Medical Therapy Program—the school-based medical therapy unit program for CYSHCN in need of on-site assessments and physical, speech, or occupation therapy. Finally, the CCS program increased the upper-age limit for high-risk infant follow-up services to 42 months.

Following are recommendations for CCS-related policy and program changes that should be sustained or implemented:

- Although service supports in the CCS program are limited to medical case management, the CCS program should leverage its registry of CYSHCN to play a “connector” role in future emergencies. Because the CSS program has unique access to the identity, service providers, and other contact information for this population, it could engage in data surveillance analysis and provide information to local CCS agencies (i.e., at the county level), special care centers, and others who may be able to serve a critical care coordination role for this population. To do this effectively, it may be necessary for the state and local CCS programs to upgrade their legacy information technology systems.
- If certain CCS functions are deferred during an emergency (such as CCS provider certification), at least some of those CCS staff at both the state and local level should engage in care coordination and SDOH assessment support (with appropriate training) for children and families, even as some of these staff may be redeployed to other disaster-related public health functions. Proactive preparations and training should occur in anticipation of this expected future scenario.
- The state and local CCS programs should coordinate to analyze the cost effectiveness of the many service authorization requests required in the program. This will determine which are important to retain and which can be eliminated, automated, or modified. External resources may be desirable to facilitate the analysis and recommendations.
- Both the state and local CCS programs should play a more prominent role in advocating for and informing about the needs of CYSHCN and their families during emergency and disaster preparedness planning. The advocacy and disaster planning guidelines for CYSHCN appeared to receive limited attention during the recent pandemic; this group should be prioritized, along with seniors with chronic conditions and other high-risk populations. Whether or not CCS program staff are an active part of this planning, they should ensure that specific and actionable recommendations and information be provided to preparedness decision-makers.

About Health Management Associates

[Health Management Associates \(HMA\)](#) is an independent, national research and consulting firm specializing in publicly funded health care and human services policy, programs, financing, and evaluation. We partner with government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations to improve health care and social services. Drawing knowledge from the frontlines of health care delivery and reform, we work with our clients to explore innovative solutions to complex challenges. HMA has 22 offices and more than 200 multidisciplinary consultants coast to coast. Learn more at healthmanagement.com.

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About the Foundation

The Lucile Packard Foundation for Children's Health unlocks philanthropy to transform health for all children and families - in our community and our world. Support for this work was provided by the Foundation's Program for Children with Special Health Care Needs. We invest in creating a more efficient system that ensures high-quality, coordinated, family-centered care to improve health outcomes for children and enhance quality of life for families. The views presented here are those of the authors and do not reflect those of the Foundation or its staff. Learn more at lpfch.org/CSHCN.



Endnotes and Citations

¹ Telehealth or telemedicine refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health.

² Synchronous refers to two-way, interactive, real-time interaction between a patient and a care provider at a distant site.

³ California Business and Professions Code Section 2242(a)

⁴ California Health and Safety Code Section 1374.14 and California Insurance Code Section 10123.855

⁵ Asynchronous and "store and forward" refer to transmission of a patient's medical information from an originating site to a health care provider at a distant site.

⁶ California WIC Section 14132.725

⁷ *Medi-Cal payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19)*, <https://www.dhcs.ca.gov/Documents/COVID-19/Telehealth-Other-Virtual-Telephonic-Communications.pdf>

⁸ *Post-COVID-19 Public Health Emergency Telehealth Policy Recommendations: Public Document*, February, 2, 2021. <https://www.dhcs.ca.gov/services/medical/Documents/DHCS-Telehealth-Policy-Proposal-2-1-21.pdf>

⁹ The federal EPSDT statutes and regulations make reference to case management and not care coordination. While those two terms and others such as care management are often used interchangeably, case management is generally understood to relate to medical care and services (e.g., assessment, planning, facilitating, coordinating, and monitoring of services required to meet medical needs with an eye toward safety, quality of care, and cost effectiveness [Case Management Society of America]). Among more than 40 definitions of care coordination, one adapted from the American Academy of Pediatrics and included in a recommended set of national care coordination guidelines for CYSHCN is: a collection of patient- and family-centered, assessment-driven, team-based activities designed to meet the needs of children and youth; care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and wellness outcomes, and efficient delivery of health-related services and resources within and across systems. (*National Care Coordination Standards for Children and Youth with Special Health Care Needs*, National Academy for State Health Policy, October 2020, <https://www.nashp.org/wp-content/uploads/2020/10/care-coordination-report-v5.pdf>). In the past 15 years, increasing focus on care coordination in programs for the adult population (e.g., section 2709 Home Health Programs, Whole Person Care Programs) have highlighted the importance of coordinating not only medical services, but also assessing for and managing a host of health-related needs, including SDOH, that influence health outcomes.

¹⁰ See recommendation 3.2 in *Meeting the Demand for Health: Final Report of the California Future Health Workforce Commission*, February 2019. The report can be accessed at <https://futurehealthworkforce.org/wp-content/uploads/2019/03/MeetingDemandForHealthFinalReportCFHWC.pdf>

¹¹ *In-Home Support Services Program: It is Not Providing Needed Services to All Californians Approved for the Program, Is Unprepared for Future Challenges, and Offers Low Pay to Caregivers. A Report of the Auditor of the State of California*, February 2021. The report can be accessed at <https://www.auditor.ca.gov/pdfs/reports/2020-109.pdf>

¹² At least one home care agency has developed family Certified Nursing Assistant training programs, now available in several states where waivers or other mechanisms have been implemented, to allow legally responsible and other family members to be reimbursed.